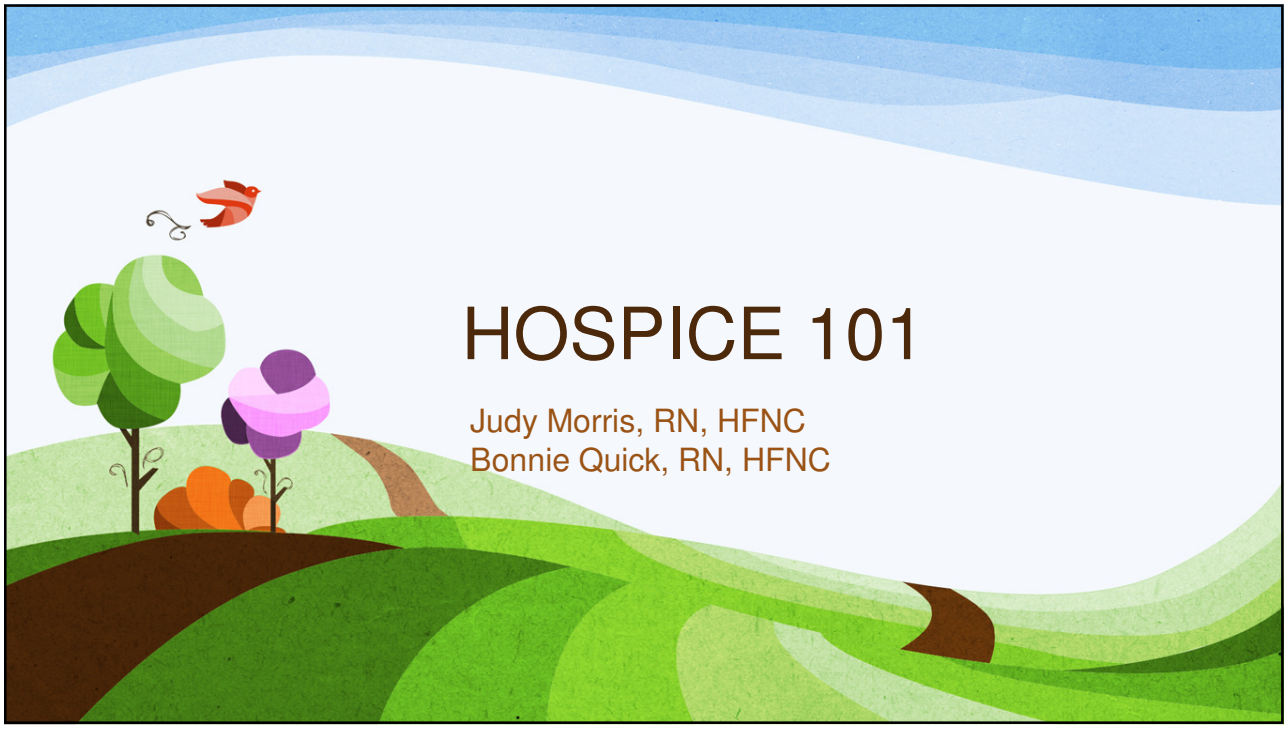

HOSPICE 101

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Hospice in general

- End of life care that serves terminal pt, family and caregivers
- Hospice must be in compliance with federal/ state regulations
- Hospice covered by Medicare part A , some insurances, private pay
- Hospice Medicare patient pays nothing for services r/t terminal dx
- Hospice services 24 hours a day/ seven days a week
- Services must be the same in all geographic areas as parent office

Hospice services by interdisciplinary team

- Nurses
- Social workers
- Doctors (Medical director and attending doctors)
- Spiritual counselors/ chaplains
- Additional services of volunteers, aides, therapists, special counselors

Primary nursing roles

- Quality care to terminally ill, with primary emphasis on comfort: control of pain and uncomfortable symptoms (IE: nausea, dyspnea)
- Patient/ caregiver education about disease process, treatment options
- Patient/ caregiver education about their role in treatment, “how to” give bedside care at home, use of available equipment, supplies
- Listen to concerns, and assess for physical, psychosocial, emotional or spiritual problems (RN case manager for each patient)
- Coordinate with other interdisciplinary team members

Interdisciplinary Group Responsibilities

- Assess and plan care that is holistic (meet physical, emotional, psychosocial and spiritual needs)
- Meet patient and family/ caregiver needs
- Ensure patient/ family accept/ understand hospice palliative care approach
- Patient may meet hospice criteria (terminal) but if not emotionally ready, patient is NOT appropriate for hospice
- Coordinate and make decisions as a team (IDG and family)

MEDICARE DEFINITION: PALLIATIVE CARE

- "CARE THAT IS FOCUSED ON PATIENT AND FAMILY THAT OPTIMIZES QUALITY OF LIFE BY ANTICIPATING, PREVENTING AND TREATING SUFFERING".

Hospice Communication with patient/ caregivers

- LISTEN and ASK open-ended questions
- ENCOURAGE open discussion of concerns, dialogue with patient/ CG
- SPEAK THE TRUTH but don't be afraid to tell them "I don't know"
- WATCH for non-verbal language, including facial expressions, and try not to interrupt or be judgmental
- CLARIFY by asking more questions, and silence is OK, to allow them time to formulate their answer
- CONFIDENTIALITY is a must, and RESPECT of their preferences

Regulatory requirements

- Federal code of regulations ("CFR") from Centers for Medicare and Medicaid (new hospice regulations in December 2008)
- Missouri code of state regulations ("CSR")
- Regulations are requirements for minimum standards of how hospice must operate, provide services
- When one regulation (IE:state) is more stringent than the other (such as a federal regulation) must follow the most stringent standard
- IE: State more stringent for IDG meetings- every 14 days vs fed's

Required Hospice Services

- IDG- Nurses, doctors, social workers, spiritual/ other counselors
- Medications/ treatments for the terminal illness (and supplies)
- Durable Medical Equipment (oxygen, specialty beds, wheelchairs, etc)
- Dietary and other counseling
- Therapies (occupational, physical, speech)
- Volunteers, personal care aides, and homemakers
- Bereavement services up to one year after patient's death

Hospice Levels of Care

- ROUTINE- at a person's home or in a nursing home
- CONTINUOUS
- INPATIENT ACUTE CARE
- RESPITE

Continuous Care

- Hourly skilled care paid by Medicare (High-risk for fraud cases)
- IDG makes decision when it is necessary (Must document contacts)
- At least eight of twenty-four hours, beginning at midnight and ending at midnight (Must document each start and ending time for care)
- Skilled nurses (RN and LPN) must give care at least half of the hours
- For a period of CRISIS when symptoms are out of control and requires skilled nursing management of symptoms for intensive timeframes

Acute Inpatient Hospice Care

- IDG team decision
- Hospice makes arrangements for inpatient admission (contracted)
- Patient / family needs are met for pain/ symptom management when caregivers are unable to handle at home with hospice assistance
- Periodic contact by hospice staff visiting patient/ family
- Hospice coordinates to ensure hospice palliative care continues. Hospice gives hospice plan of care to facility, and regular communication between hospice and facility staff

Respite Care

- Provided by hospice for relief of FAMILY/CAREGIVERS
- Maximum of five consecutive days paid by hospice at contracted facility (nursing home, some inpatient facilities such as hospice houses). Not limited to one five-day period.
- Facility provides 24/ 7 care for patient, but not required to have RN all 24 hours (Must have contract with facility)
- Family / caregivers can visit, without 24/7 responsibility, can get rest
- Coordination by hospice for transportation, DME and medications

Patient Rights on Hospice

- Many regulatory requirements from Medicare for Patient Rights
- Document patient/caregivers informed of rights (with pt signature)
- Give patient a copy of the rights, and include information on Advanced Directives (with state case law), agency policy on Advanced Directives, patient's knowledge of financial liability
- Provide information on patient rights (copy left with patient) PRIOR to hospice services implemented
- Inform patients/ family when payment of services changes

FINANCIAL RESPONSIBILITY

- Inform patient/ family of what they will owe, if any (actual dollar amount) for hospice services (Visits, medications, DME, ambulance, supplies)
- Medicare patient should owe nothing for terminal- related conditions
- If private pay or insurance, should document $ amount co-pay or deductible amounts, patient's per visit costs, etc.

ADMISSION INFORMATION

- Need to accurately document all information given at admission
- Don't mark information as "given and discussed" if not given!
- Surveyors often interview at home visits and review documents to verify what information was given/ received by patients (Pt Rights, Financial responsibility info, medications)
- Hospice plan of care and documentation should show when new supplies, DME, medications are needed, that the patient is informed of payor source, and if (IE:new medication) is not hospice-covered, reason is discussed with patient / caregiver

Advanced Directives

- Hospice must determine IF a patient has an advanced directive, and what type document that tells the patient's wishes
- Could include: living will, DPOA, medical POA, Do Not Resuscitate
- Inform patient/ family and distribute literature about types of Advanced Directives and agency policy on following Advanced Directives
- Obtain a copy of patient's Advanced Directives (AD), ask more than once if they do not give a copy at admission. Know location of AD.

Initial Assessment

- Hospice Registered Nurse must complete by 48 hours after election of hospice (including whether social worker, chaplain needed by 5 days)
- If doctor, patient/ family request earlier than 48 hours, must document that request and respond to need, and document any pt refusals
- Identifies immediate care needs: Physical, emotional, psychosocial status related to the terminal illness and co-morbid conditions
- Must make initial assessment in location where hospice services will be given (patient's home or nursing home), not in hospital before DC

INITIAL ASSESSMENT (Continued)

- Initial assessment cannot be done in hospital EXCEPT when a patient is being admitted to an acute inpatient hospice level of care due to symptom management needs (occasionally hospice begins at acute inpatient level of hospice care)
- Not a “meet and greet” visit, begins plan of care for important needs of both patient and family
- Not a “cookie cutter” beginning plan of care for any new patient
- Beginning of the comprehensive assessment

Comprehensive Assessment

- IDG must complete a comprehensive assessment by five days after election of hospice care (federal regulation-L523)
- Nature and condition causing admission (need for referrals?)
- Complications and risk factors—severity of symptoms
- Functional status
- Imminence of death
- Bereavement Risk

Comprehensive Assessment (continued)

- Drug Profile (Medication Review) that includes prescription and over-the counter, herbs, and other alternative therapies that could affect drug therapy.
- Medication Review, by RN (specially trained), pharmacist, doctor looks at drug effectiveness, side effects, actual/ potential drug interactions, identifies duplicative drugs, whether drugs require laboratory monitoring
- ALL physical needs, psychosocial, emotional, and spiritual needs (from assessments of RN, social worker, spiritual counselor)

Comprehensive Assessments (continued)

- Includes an assessment for need for volunteers, homemaker services, hospice aide services, respite care (could identify some needs in initial assessment) AND Pre-bereavement risk assessment
- Nursing home patients get same level of services offered as a patient in their private home (IE: volunteers, nurses, social worker, aides) but would not need homemaker services or respite, for instance
- Terminally ill nursing home patients often need additional personal care services due to immobility, incontinence (hospice supplements)

Update of the Comprehensive Assessment

- Changes in care and needs for services between assessment times
- Must be done by IDG collaborating with the attending physician (if any) and / or Medical Director of hospice. (Need documentation to show attending DR received IDG updates)

No less often than every 14 days (Missouri regulations) while Medicare regulations say every 15 days—Since Missouri regulation is more stringent, must be done by 14 days.

- Every assessment (initial, comprehensive and updates) must be made in person—none by phone

Plan of Care

- Individualized to each patient
- Must reflect patient/ family goals (pain, end-of-life decisions)
- Include patient/ family education needs
- Include pre-bereavement risk assessment, goals, plans
- Include all services, supplies, DME, medications, physical, emotional, psychosocial and spiritual plans to meet identified needs

Content of the Plan of Care

- Patient/ family goals
- Interventions to manage pain, symptoms
- Scope/ frequency of services (nurses, SW, chaplain, volunteer, aide)
- “PRN” is not a frequency by itself, use number (IE: 2 times a week) “and PRN” for problems you could anticipate might occur
- Measureable outcomes expected (IE: “ Pt. will have pain less than 3/10 by 48 hours after admission”)
- Progress toward outcomes- or “resolved” and date of change

Content of the Plan of Care (continued)

- Drugs and treatments
- Medical supplies and equipment needed
- Payor source of supplies/ drugs/ equipment/ labs/ xrays
- Education needs of patient/ family
- Physician orders for all meds, labs/x-rays, level of care changes
- Document caregiver/ patient agreement and understanding and IDG involvement/ collaboration (with doctor) in all plan of care changes

Wounds (Avoid deficiencies and poor outcomes)

- Wounds- common challenge with hospice patients
- Higher risk: debility from terminal illness, poor appetite, poor nutritional intake, less mobility, weight loss, develop incontinence
- Resources/ staff education for assessment, prevention, treatment of wounds (Know agency policy, see website resources on last slides)
- Need skilled intervention, excellent documentation of wound prevention, assessment, caregiver education
- See “Hospice Do’s of Documentation” and “Websites” at end of slides

Wound Prevention

- Skin assessment part of a full comprehensive assessment and each update assessment
- Don’t document “skin intact” if you did not look at coccyx, heels, all the skin areas!
- Encourage patient/caregiver to change positions at least every 2 hours, teach caregiver techniques for transfers, position changes
- Clean, moisturized skin
- Protective barriers, offloading pressure areas, no heating pads

Wound Treatment/ Documentation of Care

- Notify doctor of each wound, and follow current wound care orders
- Document weekly measurement/ description/ consistent numbering of wound sites visit to visit (Document reason for missed assessment)
- Location (site), stage, size in centimeters (length, width, depth) drainage (color- consistency), amount of drainage, odor, appearance of surrounding skin, and detailed (cleanser, dressing) care given
- Educate patient/ family re: wound care with Dr. order. Document both the teaching and their return demonstration of appropriate care

Wound Care Coordinated

- When patient is in a nursing home, hospice nurse should continue to monitor wound (visual assessment)
- Hospice nurse must coordinate with nursing home staff or patient family/ caregiver to arrange times for hospice nurse to re-assess wound
- Plan of care should say wound assessment/ care by hospice IE: “Weekly on Wednesday” and “by NH staff daily on other days”
- Example of deficiency, when hospice nurse did not perform assessment/ care

Hospice Aides/ Homemaker Services

- RN assessment of patient/ family includes need for personal care or homemaker needs
- RN (not LPN) documents Hospice Aide assignment
- Homemaker needs include: light cleaning, cooking, laundry, etc
- Specific tasks performed by aide in plan of care (aide assignment)
- Plan of care must give aide frequency (not PRN)

Hospice Aide Supervision by RN

- Must be aide supervisory visit (onsite) at least every 14 days by RN
- Aide does not need to be present, but ask patient/ family WHAT the aide does for them. Ask IF the aide treats patient respectfully, and IF the patient/ family feel the present aide performance meets the need. OBSERVE patient for presence of dirty hair, nails, signs of poor care
- RN needs to supervise and document to show whether aide is following aide assignment and whether assignment needs a change

Aide Tasks Delegated by RN

- If RN documents the aide follows the plan of care, but surveyor finds aide documentation showed not done, then we can cite a deficiency
- RN must never assign task the aide has not been trained to do
- Missouri State Board of Nursing: on delegated activities "should be limited to highly prescribed repetitive tasks that do not call for judgment" of unskilled person
- Aide can perform simple baths, shampoo, apply simple topical ointments such as barrier creams, antifungal creams. Aide CANNOT apply dressings with Panafil, Granulex, etc

RN Delegation to Aides

- Missouri State Board of Nursing takes the stance that when an unlicensed person performs nursing functions without the benefit of instruction or supervision by the RN, this constitutes the practice of nursing without a license.
- When RN delegates tasks the responsibility and accountability remains with the RN
- Assignment of aide must include a specific frequency

Aide Competency Evaluation and Training

- New aides and aides who need to be trained in certain tasks
- Basic skills / competency in bathing, transferring, performing range of motion, toileting, etc are observed and checked off by RN before the new aide sees patients on their own
- Additional skills, aides need be trained, competency evaluated by RN, and not assigned to tasks aide not evaluated/ trained to do
- Additional skills could be: transfers with mechanical lifts, catheter care, simple dressing changes (like a skin abrasion, or wet to dry NS dressing), applying TED hose, etc

Aide Assignment in Nursing Homes

- Plan of care must be coordinated in nursing homes
- Aide assigned with a specific frequency, and in NH copy of the hospice plan of care, must have what days of the week (IE: “Aide 2 times a week, on Tuesday and Thursday”)

LPN Supervision

- RN must make monthly onsite visits to evaluate LPN performance
- Does LPN provide care according to plan of care? (Review LPN documentation and ask patient/ family about care)
- Does LPN provide care that patient/ family feel is sufficient/ timely?
- Does LPN fail to notify RN of changes/ concerns of family/ patient?
- Only RN can make changes to the plan of care, not LPN, so must have good communication from LPN to RN

Education of Patient/ Family

- Must have doctor's order to teach wound care, IV administration, special skills to a patient, or a caregiver who is not a skilled nurse
- Documentation of teaching should include basic content of teaching, and competency of patient/ caregiver to perform tasks
- Observe patient/ caregiver performing tasks, and document success/ problems after their return demonstration, re-educate when needed
- If person is capable but not comfortable with procedure, they ARE NOT READY to perform alone, and task is still responsibility of staff

Pain Management and Symptom Control

- Many new regulatory requirements re: pain assessments. Remember pain is what the pt says it is. Nurse needs to assess at **each visit**.
- History of pain and treatment
- Characteristics of pain include:
  - Intensity
  - Description (burning, stabbing, dull ache)
  - Pattern
  - Location and radiation

Pain/ Symptom Management (continued)

- Frequency, timing, duration
- Impact of pain / symptom on quality of life
- Precipitating factors that exacerbate
- Factors that reduce
- Additional symptoms associated with pain
- Physical exam
- Specific medications for conditions and their effectiveness (Pain, N/V)
- What are the patient/ family goals for pain management/ satisfied with current treatment?

Medication List (Drug Profile)

- All drugs listed on Medication Profile and must have doctor's order
- Order complete with drug name, dose, frequency, route
- Only doctor or Nurse Practitioner (per state law) may order drugs
- New Medicare regulation (L690)- If the order is verbal or an electronic transmission, it must be given to a licensed nurse, NP, pharmacist or physician (Not PT, SW, Chaplain)
- Person receiving order must record and sign immediately and have prescribing person sign it (Any order-not just medication orders)

Medication Orders and IDG Responsibility

- Medication orders for drugs with variable doses must include dose/ frequency/ route and reason (IE: PRN for "pain", "nausea", "dyspnea")
- Medications must be reviewed with patient/ family, document drugs discussed, patient/ family understanding
- IDG reviews the POC and patient/ family ability to safely administer drugs in the home setting (New Medicare regulation L692)
- Hospice must provide, discuss, document: Copy of agency policy given to the patient/ caregiver on controlled drug management (new Medicare regulations (L696-L697)

Medication Management

- If there is a discrepancy found in controlled drugs it must be IMMEDIATELY investigated by pharmacist and hospice Administrator
- Notify prescriber of missing controlled substances
- IDG decides how to best control administration of controlled substances (IE: Lock box, one person only with access)
- So hospice nurse must periodically count controlled substances and provide oversight/ education of family or caregivers who have access to patient's medication

Standing Orders (SO)

- Not all hospices use these
- S/O must specify each procedure, medication or treatment. IE: medication strength, dose, frequency
- Each procedure, medication or treatment should have specific criteria for when to use (indications for use, purpose, conditions)
- Specific criteria do not allow nurse's choice (IE: Multiple drugs or dose ranges allow choice, unless they are listed as steps in a process, with degrees of symptoms defining when to go to the next step, using an increased dose. Keeps all staff consistently approaching same way.)

Standing Orders (continued)

- Standing orders (S/O) must have physician's signature, date
- Hospice Medical Director must review all standing orders annually
- Hospice should have policies as to when to use standing orders, and how to implement these
- Must notify the doctor of initiating one of the standing orders, and it can be phoned or faxed (must be documented)
- S/O must be individualized, for each patient needs. This cannot be a "one size fits all".

Comfort Packs (not Federal hospice regs)

- Not required but some hospices use these (Not in SNF)
- Should be emergency dose only! Not a month's supply.
- Based on careful nursing assessment of appropriateness.
- Should never be part of a standing order, but based on individual needs assessed, after home safety assessment (kept in locked box)
- Physician order for each separate medication in the comfort pack
- Should not duplicate medications already in use in the home

Comfort Packs VS Standing Orders

- Comfort Packs are medications placed in a locked container in the home anticipating need eventually (IE: Pain, cardiac, seizure)
- Drugs and treatments listed in Standing Orders are not kept in the home, but would need an individual prescription. Nurse would call in a medication order and fill at pharmacy when implementing the standing order.
- Would need individual prescription for each drug from the standing orders.

Delivery of Controlled Substances

- Documentation is very important- it verifies delivery and receipt of controlled substances—Follow your agency policy.
- Documentation when a controlled drug is delivered to the home includes: (ML217)
  - Date
  - Patient name
  - Medication name
  - Strength and quantity indicated on prescription container
  - Signatures of hospice staff and receiver (patient/ caregiver)

Disposal of Controlled Substances

- If drugs destroyed in the home at the time of death, document name of each medication destroyed
- Quantity of each medication destroyed
- Hospice nurse signs and dates the destruction form
- Follow your agency policy for method of destruction/ documentation
- Signature of a witness (family or other staff), but if CG refuses, document that agency policy was provided, and family situation
- NEVER REMOVE ANY MEDICATIONS FROM THE HOME

Revocation (Federal regulation only)

- Revocation is a decision of patient/ family to revoke the Medicare benefit for hospice and discontinue hospice care
- The hospice CANNOT revoke the patient—cannot coerce patient
- Document the date of revocation, signed by patient or their representative (subpart B 418.28), and specific reason pt revoked
- IDG must be informed of the revocation
- Discharge summary must be sent to DR, and a copy of the clinical record (if requested by DR)

Discharge Summary

- When patient discharges due to decertification (no longer meeting hospice criteria), or transfers to another Medicare/ Medicaid certified facility, or revokes hospice (Medicare regulations L682,683, 684)
- Includes summary of patient's treatment, symptoms, and pain management
- And current plan of care and physician's orders
- Any other documentation that would assist in discharge continuity of care, or other documentation requested by attending doctor/ receiving facility. Make sure to document date sent to doctor/ facility

Transfer/ Change of Designated Hospice

- Clinical record should be complete story of information about transfer
- Include reason for transfer- why patient requested the transfer
- Transfer summary must be sent to receiving provider with at least:
  - Current medication list
  - Advanced Directives information
  - Problems that require intervention/ more follow-up
  - Discharge summary to physician (as described above)
  - Copy of clinical record, if requested by receiving provider

Transfer Form Requirements

- If transfer to another hospice, must use a transfer form
- Signed by patient/ their responsible representative
- Include transfer date
- Name of transferring hospice
- Name of receiving hospice (Subpart B 418.30) (c) (1) (2)
- Surveyors will look at the transfer form for the date the information was sent to receiving hospice

Discharge from Hospice

- When hospice decides to discharge patient, must see documentation of IDG team decision/ involvement and supporting reason for DC
- Must be a written doctor's order, by Medical Director
- Must be documentation that the attending doctor was consulted
- Discharge summary must be sent to the attending doctor
- Referrals to necessary/ appropriate resources (DME, in-home services, for instance)

Discharge Reasons

- Clinical record should show the reason for discharge
- Should have documentation that the patient/ their legal representative was notified of the date and reason for discharge
- Three reasons for discharge:
  - 1. Moved out of the service area
  - 2. Extended prognosis (patient stable and not deteriorating)
  - 3. Discharge for cause (as described by Medicare specifically, and should follow an agency policy, with involvement of IDG and Administrator/ Director)

Hospice in a Nursing Facility

- Coordination, between hospice and nursing facility, for patient care is mandated by Medicare regulations for both entities
- Hospice plan of care must be established in consultation with facility
- Hospice POC identifies care and services that are needed and specifies which provider (hospice, nursing home, or both) will provide
- See example of the Hospice Advisory Council's sample coordinated plan of care for hospice and nursing home (Handout)

Clinical Record Shared (NH and Hospice)

- Hospice documentation must be in a clinical record in a NF
- Could be in a section of NF chart, or in a separate hospice chart that is kept with clinical records in the NF
- Surveyor will ask both NF staff and hospice to identify the hospice clinical record. (Be sure NF orders also copied to hospice records.)
- We must see the same level of care in NF as in a private home (including volunteers, aides)
- Sometimes a tendency for hospice to let NF staff provide most care

Coordinated Plan of Care

- Coordination with hospice, nursing facility, patient, family/ significant other all participate in planning coordinated care
- Hospice updates their hospice plan of care to reflect changes in collaboration/ discussion with the patient/ family/ nursing home staff
- Federal regulations say IDG member is responsible for overall coordination/ communication with nursing home facility BUT--
- State regulations specify (ML 255) a registered nurse is responsible
- Attendance at NH quarterly care planning can be delegated (IE: SW)

Hospice Provides to Nursing Home

- Copy of current hospice plan of care (and updates)
- Copy of hospice election form signed by patient
- Advanced Directive information
- Physician signed certification and recertification statements
- Contact information for hospice personnel (with 24/7 on-call system)
- Current medication list
- Copy of all physician orders for this patient (hospice and attending)

On Call / After Hours Hospice Services

- Nursing care, physician care, drugs/ biologicals must be available 24 hours every day, and other services (DME ,crisis counseling) that are needed, if reasonable, must also be available 24/7 (L 653)
- Missouri regulation says if it is an emergency situation, when patient calls, visit must be made within an hour.
- Must document specific time the call was received, from patient/ caregiver, and the time of arrival to see patient.
- Includes nursing home patients

On Call/ After Hours (continued)

- For non-emergent call, with needs that require a visit but not an emergency, staff should make a visit within three hours (Missouri reg)
- Document what the caller wanted and what they described as need (be sensitive to needs of the caregiver(s) as well as the patient)
- If a visit was not made, need to document why
- Your documentation is the only way to show the patient needs were met, and determine if you made the right call. Otherwise we would go by complaints/ descriptions of what happened given by family to surveyors or others!

Prioritizing On-Call

- If patient or family member contacts hospice after hours, it is obviously very important to them, and needs to be very important to hospice staff, too!
- Includes nursing home staff calls after hours, also
- OVERALL:
  - Remember the clinical record is a legal document. Complete, accurate and specific documentation is a must. Your documentation could be called into a court of law… **MAKE SURE IT DEFENDS AND SPEAKS FOR YOU**!


Bureau of Home Care and Rehabilitative Standards
Phone: 573-751-6336
Email: judy.morris@health.mo.gov


Bureau Talk (newsletter)
www.health.mo.gov/safety/homecare
New hospice federal regulations Jan. 2009, attachment D

Handouts in Attachments

- See handout on Coordinated Task Plan (for Hospice and Nursing Homes)
- See handout on "Hospice Do's of Documentation"
- See handout on Websites for hospice regulations and Resources for wound assessments/ care
- QAPI (Quality Assessment/ Performance Improvement) tool